(16) (1H)

Nos. 84-325 and 84-356

IN THE

Supreme Court of the United States

OCTOBER TERM, 1984

METROPOLITAN LIFE INSURANCE COMPANY,
Appellant

v.

COMMONWEALTH OF MASSACHUSETTS

THE TRAVELERS INSURANCE COMPANY,
Appellant

v.

COMMONWEALTH OF MASSACHUSETTS

On Appeals from the Supreme Judicial Court for the Commonwealth of Massachusetts

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BRIEF AMICUS CURIAE OF THE NATIONAL ASSOCIATION OF ALCOHOLISM TREATMENT PROGRAMS, INC.

IN SUPPORT OF AFFIRMANCE

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QUESTION PRESENTED

Whether a Massachusetts law, Mass. Gen. Laws, Ch. 175, § 47B, mandating minimum health coverage by health insurance policies is preempted by the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1144(a) *et seq.*, and the National Labor Relations Act ("NLRA"), 25 U.S.C. § 151 *et seq.*

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INTEREST OF AMICUS CURIAE

The National Association of Alcoholism Treatment Programs ("NAATP"), a not-for-profit corporation, is an association representing nearly 400 specialty hospitals, centers and units in 46 States dedicated exclusively to the treatment of the disease of alcoholism. The Association includes both not-for-profit and investor-owned entities. Health care services are offered by NAATP members in inpatient hospital, outpatient and freestanding residential settings. The primary goals of the organiza-

tion are to raise public awareness of alcoholism as a treatable disease; to promote and maintain the highest standards of health care in the treatment of alcoholism; to attain more adequate reimbursement for services; and to provide programs of continuing education to those who administer and coordinate alcoholism treatment programs. NAATP serves as official liaison from the alcoholism treatment field to the Joint Commission on Accreditation of Hospitals. NAATP's members, through their commitment to the organization's Principles of Practice, provide high quality care in this most crucial health area.

NAATP as well as its members have a vital interest in these appeals because they will resolve an issue that is of paramount interest to the mental health care field, in general, and specifically to the alcoholism treatment area —namely, whether Massachusetts (and other States) can mandate that health insurance policies covering that State's residents provide minimum benefits for the inpatient hospital, outpatient and residential treatment of certain treatable illnesses.

SUPPLEMENTAL STATEMENT OF THE CASE

The Commonwealth of Massachusetts' ("Commonwealth") brief on appeal discusses the issue of the inapplicability of preemption under ERISA and NLRA and the Committee for Comprehensive Insurance Coverage's ("CCIC") amicus curiae brief will discuss the same issues only limited to ERISA. NAATP joins in the Commonwealth's and the CCIC's arguments and incorporates them by reference in this brief. Although these cases directly involve mandated benefits relating to mental and nervous conditions, Mass. Gen. Laws, Ch. 175 § 47B, they indirectly will impact on similar mandatory coverage legislation, such as the Massachusetts laws relating to provision of alcoholism treatment coverage. Mass. Gen. Laws, Ch. 175 § 110; Ch. 176A § 10; Ch. 176B § 4A ½; Ch. 176G § 4.

In this brief, NAATP will catalogue the devastating human, economic and societal impact of alcoholism, demonstrate the recognition of alcoholism as a disease which should be and can be treated and discuss the consequential need to permit States to exercise their traditional insurance regulatory powers to mandate insurance coverage for treatable diseases. NAATP will also establish that, contrary to the insurance companies' apparent fears of negative financial impact, the cost of neglecting alcoholism treatment far outweighs the costs of providing adequate treatment.

Accordingly, the NAATP submits this *amicus curiae* brief, with the consent of the parties, in support of the Appellee to urge this Court to affirm the judgment of the Supreme Judicial Court of Massachusetts.

SUMMARY OF ARGUMENT

These cases require the Court to decide whether States can mandate that health insurance policies issued within their borders must provide the insureds with certain enumerated minimum benefits for the treatment of chronic treatable diseases. It is a well established legal principle that such control over the terms of insurance contracts is an inextricable aspect of insurance regulation, which has traditionally been left with the sole discretion of States. As will be argued in the briefs of the Commonwealth and the CCIC, such entrenched sovereignty was not preempted by ERISA or NLRA.

In addition to those legal principles, however, the social, human and economic costs of treatable but inadequately covered diseases justify such State laws and regulations. Mental health and alcohol/drug abuse disorders have a profound and severe effect on our entire society. Although alcoholism is widely recognized as a disease by professional organizations and governmental bodies, alcoholics are nevertheless ignored by many insurance companies, despite the irony that treating alcoholism costs

less, in the long term, than treating the acute and chronic consequences of that disease.

The trend towards mandated benefit laws reflects the independent judgment of numerous legislatures that alcoholism, and similar disorders, must be treated to alleviate the tremendous fiscal and social costs to the individual alcoholic, his family and society. It also reflects the judgment of State insurance regulators that coverage of diseases such as alcoholism is an obligation of those very insurers which are granted licenses by the States to conduct business in those jurisdictions.

ARGUMENT

I. WIDESPREAD USE AND ADVERSE CONSEQUENCES OF ALCOHOL MANDATES TREATMENT AND COVERAGE OF ALCOHOLISM

The need for effective alcoholism treatment[1] is mandated by the extent of the use of alcohol in the United States. Indeed, alcohol is regarded as the most widely

[1] Alcoholism is understood "as a complex disease with biological, psychological, and social features and causes." Blume, Sheila B., M.D., "Public Policy Issues," *Alcoholism and Related Problems* (1984), at 180. Another commentator in the field of alcoholism has defined that term to mean "an illness caused by the prolonged ingestion of ethyl alcohol (especially in biologically vulnerable people) and manifested by a variety of harmful physical, mental, behavioral, and social effects." West, Louis Jolyon, M.D., "Alcoholism and Related Problems: An Overview," *Alcoholism and Related Problems* (1984) at 1. *See also* Pennsylvania Task Force on Substance Abuse and Insurance Benefits (March 1981), which at page 12 states: "The disease of alcoholism is characterized by physical and/or psychological dependence or addiction to alcohol. Alcohol abuse and/or alcoholism represents the use of alcoholic beverages in a manner that impairs health and/or results in a loss of ability to control actions and maintain a socially acceptable life adjustment." In *Diagnostic and Statistical Manual of Mental Disorders* (3rd ed. 1980), at page 169, alcoholism (also known as alcohol dependence) is defined as "either a pattern of pathological alcohol use or impairment in social or occupational functioning due to alcohol, and either tolerance or withdrawal."

used and abused drug in the United States. As noted by one commentator, "[a]lcohol is a drug. It is the No. 1 drug of abuse in our society. Its only close rival is tobacco. Both are legal." Lundberg, George D., M.D., "Ethyl Alcohol—Ancient Plague and Modern Poison," *Journal of the American Medical Association* (October 12, 1984), ("JAMA") at 1911. The magnitude of alcohol consumption was starkly depicted by a finding in 1981 that the equivalent of approximately 2.77 gallons of pure alcohol was sold per person over the age of 14. National Institute for Alcohol Abuse and Alcoholism, *Fifth Special Report to the United States Congress on Alcohol and Health from the Secretary of Health and Human Services* (December 1983), at xiii ("Fifth Report"). Put another way, each person in this country consumes, each year, about 591 12-oz. cans of beer, 115 bottles of wine or 35 fifths of 80 proof whiskey, gin or vodka. *Id.* In reality, this level of consumption is concentrated because approximately one-third of adults abstain, one-third have about two drinks per week, and the remaining third consumes an average of 14 drinks per week. *Id.* The foregoing averages still do not paint an accurate picture considering the estimate that a tenth of the drinking population consumes one-half of the alcoholic beverages sold in the United States. *Id.*

The most alarming fact is that heavy use of alcohol is not restricted to adults. The *Fifth Report* states that approximately 56 percent of ninth graders have tried alcohol. By the time they have reached their senior year in high school, more than nine out of ten students have used alcohol. Approximately 41 percent of the high school seniors reported that they had consumed five or more drinks on a single occasion within two weeks of the survey. Six percent stated that they drink on a daily or nearly daily basis. *Id.*

Whether adults or children are involved, excessive alcohol consumption has serious, and costly, medical impli-

cations. Unfortunately, the consequences of alcoholism are neglected by many insurance companies due to their outmoded and unjustifiable views of the costs of insuring alcoholism treatment. Given the magnitude of the alcoholism problem, however, it actually costs less to provide such benefits than to treat alcoholism's acute and chronic consequences.

A. The Devastating Effects of Alcoholism Mandate Treatment and Coverage

The level and concentration of alcohol consumption have drastic effects on individuals who actually consume alcohol, as well as upon non-consuming innocent third parties. Only adequate treatment, facilitated by insurance coverage, can measurably reduce these dire effects.

(1) *Human Costs*

The ingestion of even small amounts of alcohol results in immediate short-term physical reactions in the body. In addition, the use of alcohol in large quantities over an extended period of time often results in irreversible damage to virtually every organ in the body.

Alcohol is immediately absorbed into the blood. The blood transports the alcohol to the brain where it depresses inhibitory responses and reduces muscle tension. Berkowitz, Howard; Arthur Leyland, Jr. and David Strachan, *Alcoholism Benefit Project: An Interim Report* (Blue Cross and Blue Shield, 1980) ("Interim Report") at I:13. As the quantity of alcohol in the bloodstream increases, the drinker's coordination decreases. Other immediate short-term effects are slurred speech and confused thought processes. Thus, the drinker becomes unable to communicate in a coherent manner. If a drinker continues to ingest alcohol, he will lose consciousness before he is able to consume enough alcohol to completely extinguish the activities of his central nervous system, the result of which would be death. In fact,

it is possible to die from alcohol ingestion if the individual drinks a large enough quantity to prevent the body from being able to metabolize the alcohol to non-toxic and non-sedating substances. *Interim Report* at I:13-14.

The digestive system, including the mouth, esophagus, stomach, intestine and pancreas, is adversely affected by the consumption of large quantities of alcohol. For instance, alcoholics have a larger risk of cancer of the mouth, tongue, pharynx and esophagus than non-alcoholics. *Fifth Report, supra,* at 45. The pancreas is often structurally changed by excessive alcohol intake. Chronic pancreatitis is observed in many alcoholics. Additionally, over half of the alcoholics without pancreatitis symptoms show some pathologic changes in the pancreas. *Fifth Report, supra,* at 47.

The liver also is highly affected by excessive alcohol consumption. Liver diseases, including cirrhosis and hepatitis, occur more frequently in alcoholics than in non-alcoholics. Cirrhosis was the eighth leading cause of death in the U.S. in 1979. *Fifth Report* at 7. Additionally, in a Canadian study, data showed that 80 percent of deaths due to liver disease were alcohol related. Wolf, Stewart G., M.D., "Alcohol and Health: The Wages of Excessive Drinking," *Alcoholism and Related Problems* (1984), at 31-32.

Excessive alcohol consumption adversely affects the heart and skeletal muscle systems of the body. The heart muscle's pumping action is decreased whenever alcohol is consumed. Thus, for instance, cardiomyopathy, a heart muscle disorder which is the result of damage to the heart, is found in as many as 50 percent of alcoholics who have ingested large quantities of alcohol over a long period of time. National Institute of Alcohol Abuse and Alcoholism, *Fourth Special Report to the United States Congress on Alcohol and Health From the Secretary of Health and Human Services* (January 1981) ("Fourth

Report") at 46. A direct correlation exists between hypertension and the daily ingestion of large amounts of alcohol and incidents of strokes. *Id.*, at 47.

The endocrine system also is damaged by the excessive use of alcohol. One 1980 study showed that 70 to 80 percent of alcoholic men have a decreased libido and/or impotence. *Fifth Report*, *supra* at 55. In female alcoholics, the ovaries fail to produce hormones resulting in the loss of secondary sex characteristics and infertility. Id., at 55. *See also* Institute of Medicine, *Alcoholism, Alcohol Abuse and Related Problems* (1980), at 55.

The nervous system is adversely affected by excessive alcohol intake. For instance, it has long been acknowledged that loss of brain cells results from alcoholism. Brain atrophy was found by Parsons (1977) to be present in 50 to 100 percent of alcoholics. *Fourth Report*, *supra*, at 53. *See also* Institute of Medicine, *Research on Mental Illness and Addictive Disorders* (October 1984), ("IOM 1984") at 27. In addition, neuropsychological impairment occurs in alcoholics. Thus, for instance, alcoholics perform lower on tests such as visual-spatial and perceptual-motor tests than their non-alcoholic counterparts. *Fourth Report*, *supra*, at 55.

The harmful effects of alcohol are not confined to the actual user. Children born to women who ingest large quantities of alcohol during pregnancy may suffer from a number of alcohol-related effects, including fetal alcohol syndrome. As a result infants suffering from this syndrome may exhibit retardation in growth; a pattern of abnormal features of the head and face; and abnormal neonatal behavior or mental retardation. As many as one to three infants per 1,000 may have fetal alcohol syndrome. *Fifth Report*, *supra*, at 70. *See also IOM 1984*, *supra*, at 26. Other alcohol-related effects on the unborn include miscarriage, lower birth weight and physical congenital anomalies.

Non-alcoholics also are directly harmed by alcoholism, because alcoholism is causally related to a large number of accidents. The National Highway Traffic Safety Administration ("NHTSA") maintains data relating to all traffic crashes in which a fatality occurred. In 1981, NHTSA reported that 43 percent of all fatal crashes involved alcohol. *Fifth Report*, *supra*, at 9. Frequently single-vehicle accidents are alcohol-related. In 1981, 41 percent of single-vehicle fatalities and 45 percent of single-vehicle accidents in the 16- to 24-year-old age group involved alcohol. *Id.*, at 9. Clearly the mix of alcohol and driving create a significant increase in traffic accidents.

The risk of accident to pedestrians increases two-fold if the pedestrian has a blood alcohol count above .10 percent and it increases five-fold if the blood alcohol content is above .20 percent. Research has shown that, of all fatally injured pedestrians, there was measurable blood alcohol content in 35 to 74 percent of the cases. *Fifth Report*, *supra*, at 85. Alcoholism even affects the safety of air transportation. For instance, the United States Transportation Safety Board in 1979 found that of 678 fatal plane crashes, 30 pilots were alcohol impaired. *Id.*, at 85.

Alcoholism also has negative effects on the family and may result in tragic social consequences. There is evidence to suggest that separation and divorce among alcoholics and their spouses is seven times that of the general population (Paolino and McGrady, 1977), *Fifth Report*, *supra*, at 89. It is also estimated that alcoholics have poor marital relationships in 33 to 40 percent of the cases. *Id.* In 45 to 60 percent of spouse abuse cases, alcohol is a factor. (Hamilton and Collins, 1981). *Id.*, at 91.

Children of alcoholics often have psychological problems which can be attributed in part to an alcoholic parent or parents. Those children may exhibit antisocial behavior with other children and also may have additional problems in school. (Sher and McGrady.) *Id.*, at 92. While no clear figures are available, it seems that alcohol is involved in anywhere from 11 to 17 percent of child abuse cases. *Id.*, at 91.

Several studies have shown that between 15 to 64 percent of attempted suicides involve persons drinking alcohol, while 30 to 80 percent of actual suicides are committed by persons who were under the influence of alcohol. *Alcoholism and Related Problems, supra,* at 12.

Alcoholics lose more time from work than non-alcoholics, the time they do work is less productive and marked by diminished job performance. Alcoholics also may affect others at work. For example, the alcoholic may not get along with his or her fellow workers and may not interact well with them. *Interim Report, supra,* at I:14-15. If an alcoholic is responsible for completing certain tasks which are left undone, he or she may cause others to be unable to finish their work. As will be discussed below, the social cost of such loss of productivity is immense.

In sum, the human costs of alcoholism are significant. Users and innocent third parties alike suffer pain, injury and death because of alcoholism. These human costs alone justify mandated insurance coverage of alcoholism treatment to insure that alcoholics receive adequate treatment.

(2) *Economic Costs Related to Alcoholism Are Severe*

In addition to the tremendous human costs stemming from alcoholism which alone mandate far more attention from a treatment and coverage point of view, there also

are economic costs of significant magnitude associated with this national health problem.[2] These severe economic costs are borne by society as a whole. These costs only begin with the statistic that Americans spent approximately $56 billion on alcoholic beverages in 1980 which constituted 2.8 percent of total consumption expenditures in the United States. Cook, Philip J., Ph.D., "The Economics of Alcohol Consumption and Abuse," *Alcoholism and Related Problems, supra,* at 57.[3]

In aggregate terms, one authoritative study analyzed the enormous societal costs of alcoholism, concluding that the expenditures due to excessive alcohol consumption in the United States were $49.37 billion in 1977, which is equivalent to over $82 billion in 1983. Cruze, et al., *Economic Costs to Society of Alcohol and Drug Abuse*

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[2] The Honorable Margaret M. Heckler, Secretary of Health and Human Services, aptly summarized the magnitude and the detrimental effects of alcoholism in the United States as follows: "[T]he price of alcohol abuse to the American people is appallingly high. And that price is paid by all of us. The cost to our economy has been estimated at over $49 billion each year. But the dollar cost is only the beginning. The cost in human pain and misery, disease, and death is still more staggering. Accidents on our streets and highways claim about 50,000 Americans' lives each year—leaving another 150,000 permanently disabled. Half of those tragedies are alcohol-related. Alcohol's role in disrupting family life is less easily documented, but few doubt that it is significant. One in three Americans surveyed last year felt that alcohol caused problems in his or her family." *Fifth Report, supra,* at v.

[3] For purposes of analysis, it is useful to distinguish between direct and indirect costs. Direct costs include such items as costs of prevention, treatment and rehabilitation. Indirect costs result from the loss of productivity flowing from the illness of alcoholism. There is a potential inverse relationship between direct and indirect costs. Specifically, as expenditures on prevention and treatment rise indirect costs of the disease will fall. Fein, Rashi, *Alcohol in America, The Price We Pay* (1984), at 21-22.

and Mental Illness (1977).[4] *See also* Berry, Boland, Smart and Kauch, *The Economic Cost of Alcohol-Abuse*

[4] These costs are set forth in the following chart:

ECONOMIC COSTS TO SOCIETY OF ALCOHOLISM

($ in millions)		1977	1983 equivalent
Core Costs			
Direct:			
Treatment		$ 5,637	$ 9,425
Alcoholism treated in specialty settings	$ 707		
Alcohol-related illness and trauma	$ 4,930		
Support (research, education, training, construction, insurance administration)		735	1,229
Indirect:			
Premature mortality		10,715	17,916
Morbidity resulting in reduced productivity,		26,074	43,596
Lost work time	$23,593		
Lost employment	$ 2,481		
Total Core Costs		$43,161	$72,166
Other Related Costs			
Direct:			
Motor vehicle crashes (funeral, legal/court, etc.)		$ 1,782	$ 2,979
Criminal justice system		1,685	2,817
Social Welfare program administration		142	237
Other (fire losses, fire protection, highway safety)		832	1,391
Indirect:			
Alcoholics incarceration		1,418	2,371
Others' lost worktime due to motor vehicle crashes		354	592
Total Other Related Costs		$ 6,213	$10,387
TOTAL ECONOMIC COSTS		$49,374	$82,553

Fein, *supra*, at 27.

1975 (1977). Almost 75 percent of the total costs in 1977 are attributed to indirect costs, *i.e.*, lost productivity due to the illness of alcoholism. One commentator aptly summarized the severe costs related to alcoholism:

> 1) Alcoholism is a very costly disease. Yet it is far, far costlier than most of us imagine since few of us appreciate its very substantial impact on productivity.
>
> 2) Productivity losses alone are four times the amount expended on treatment costs (including costs of medical care for alcohol-related conditions). When we take account of excess mortality and morbidity, crime, accidents, fire, and similar consequences of alcoholism, we find that collectively these costs are nine times the treatment costs. These ratios increase markedly if we limit treatment costs to alcoholism treatment only.
>
> 3) It is no exaggeration to suggest that the state of health of the American economy, as well as that of the society, is severely affected by the presence of alcohol abuse and alcoholism. It is also no exaggeration to suggest that the size of the expenditures on specific treatment of alcoholism (about $1.1 billion) bears little relation to the negative economic and social impacts of the disease.

Fein, *supra*, at 30.

The foregoing severe individual, social and economic costs can be avoided, or at least substantially lowered, with treatment of alcoholism. Treatment, however, to be effective must be covered by insurance policies similar to those policies ensuring availability of treatment for other less devastating illnesses. Although alcoholics may agree to be treated for this disease, "because of the inadequate [insurance] coverage, the alcoholic will have to pay much or all of the cost of treatment . . . It doesn't take much imagination to see that under these circumstances, many

alcoholics pressing to make ends meet will find one excuse or another to stay out of the treatment program." [5]

II. ALCOHOLISM IS WIDELY RECOGNIZED AS AN ILLNESS THAT MUST BE ADDRESSED

Although much of the insurance industry has failed to provide adequate coverage because of an erroneous assumption that such coverage will be too costly, virtually every segment of society, including the medical profession, Federal and State governments, has recognized that alcoholism is a treatable disease that must be adequately treated precisely to avoid its costly consequences.

A. The Medical Profession Has Recognized Alcoholism as a Treatable Illness

Alcoholism has long been recognized by health professionals [6] as a serious illness affecting millions of Americans each year. In 1956 the House of Delegates of the American Medical Association ("AMA") issued a statement explicitly acknowledging that alcoholism is an illness that falls within the profession of medical practice. It published in 1968 its *Manual on Alcoholism*, which has since been periodically revised to incorporate advances in the understanding and treatment of alcoholism. The AMA also has initiated efforts to increase the awareness of physicians and educate them about addictive disorders, such as alcoholism, by publishing its *Manual on Drug Abuse*. Focusing on the addiction problems in the medical profession, the AMA also has sponsored a series of conferences on the "impaired physician" in order "to stress the very important fact that alcoholism . . . can be successfully managed through humanistic and scientific treatment." [7]

As recently as 1984 the AMA's Center for Health Policy polled physician's attitudes concerning alcohol abuse. Commenting on that poll, JAMA notes that "the respondents almost unanimously believed that alcoholism is a major national (indeed international) problem and that *it is a disease entity.*" (Emphasis added.) "Alcoholism—A Problem in Perspective" *supra* at 1912. Nevertheless, the need for treatment and coverage is as acute today as ever. Given the magnitude of the problem, treatment and coverage must be expanded dramatically.[8]

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[5] *The 1982 Report on Drug Abuse and Alcoholism*, Joseph A. Califano, Jr. (1982) ("1982 Report), at 223.

[6] Former Secretary of Health, Education and Welfare, Joseph A. Califano, Jr., summarized the extent of the disease by noting that: "Alcoholism is one of America's four top diseases. In the deaths it causes, the number of people it grips, and the economic toll it exacts, alcoholism is gaining fast on heart and circulatory disease, cancer and respiratory illnesses. If we don't act now to fight the disease with prevention, treatment, and research, alcoholism could be America's number-one disease in less than twenty years, before the end of this century." *1982 Report, supra*, 147.

[7] Niven, Robert G., M.D., "Alcoholism—A Problem in Perspective," *JAMA* (October 12, 1984), at 1912 (Dr. Niven is the Director of the National Institute on Alcohol Abuse and Alcoholism).

[8] NAATP has testified before the Congress on the urgency to treat the devastating illness of alcoholism: "It is known that alcoholism and alcohol abuse contribute to some 25 other known diseases, including cirrhosis, heart disease, pancreatitis, gastritis, peripheral neuropathy, and others. In addition, research indicates that more than 20% of all hospital admissions comprise patients with alcohol-related problems. This equates to an estimated $65.6 million spent daily treating the consequences of alcoholism while comparatively few of these patients are ever treated or even diagnosed for their primary disease: alcoholism. In fact, the National Institute on Alcohol Abuse and Alcoholism estimates that only 15% of alcoholics in need of treatment ever receive that treatment—a statistic which has not changed since 1974. *That more persons are treated annually for the consequences of alcoholism than for alcoholism, while 85% of alcoholics are never treated at all, indicates a need for expansion of services and coverage for alcoholism treatment.*" (Emphasis added.) Statement of NAATP, Robert A. Rundio, President, before the Subcommittee on Compensation and Employee Benefits, United States House of Representatives, on H.R. 656 "The Federal Employees Health Benefits Reform Act of 1983," July 28, 1983.

B. The Congress Has Recognized That Alcoholism Is an Illness of a National Magnitude That Must Be Addressed

After comprehensive hearings and extensive deliberation, the Congress has recognized that alcoholism and all of its adverse consequences constitute a severe national problem and, thus, has appropriated large sums of money to research and facilitate the treatment of the disease. It took the initiative in dealing with this national problem in 1968 by enacting the Alcoholic Rehabilitation Act of 1968, Pub. L. No. 90-574, 82 Stat. 1006 (1968) stating that "[a]lcoholism is a major *health* and *social* problem." (Emphasis added). 42 U.S.C. § 2688e(a)(1) (Omitted). Congress further declared that "[t]he handling of chronic alcoholics within the system of criminal justice perpetuates and aggravates the broad problem of alcoholism *whereas treating it as a health problem permits early detection and prevention . . . and effective treatment and rehabilitation . . . .*" (Emphasis added). 42 U.S.C. § 2688e(a)(3) (Omitted).

Subsequently on December 31, 1970, the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970, Pub. L. No. 91-616, 84 Stat. 1848 (1970) was passed requiring the Federal government to have alcoholism treatment programs for its employees. 42 U.S.C. § 290dd-1(a). It also established the National Institute on Alcohol Abuse and Alcoholism ("NIAAA") to study and promote the treatment of alcoholism. 42 U.S.C. § 290aa-1(a). That agency has played a continuing vital role in raising the level of awareness of this national health disaster. Federal law also provides that Federally qualified health maintenance organizations must provide alcoholism treatment services for their enrollees. The Federal Medicare program covers up to 21 days of inpatient treatment of alcoholism under 42 U.S.C. § 1395y(a)(1). Alcoholism treatment for members of the Armed Forces is also required in 10 U.S.C.

§ 1090. Moreover, the Civilian Health and Medical Program of the Uniform Services ("CHAMPUS") provides coverage for alcoholism treatment for spouses and children of active, retired or deceased members of the armed services in 10 U.S.C. § 1079 and the implementing regulations, 32 C.F.R. 199.10(b)(4). In addition, the Congress' concern with alcoholism is reflected in its fiscal 1985 appropriations for NIAAA in the amount of approximately $61 million for research into the causes and treatment of this debilitating illness.[9]

C. State Legislatures Have Mandated the Coverage of the Disease of Alcoholism

Although numerous professional organizations, as well as the Federal government, have come to recognize alcoholism as a disease that must be addressed, the insurance industry has not kept pace because of an unfounded fear that adequate coverage will result in higher costs to the industry. As noted by the National Coalition for Adequate Alcoholism Programs, ". . . coverage remains minimal. We are a long way from a comprehensive approach, and there is resistance by some insurance carriers and purchasers of group policies." National Coalition for Ade-

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[9] Even the Federal courts have recognized that alcoholism is a disease which cannot form the basis of a crime but which must be treated. The United States Court of Appeals for the Fourth Circuit, in a leading opinion, held that a chronic alcoholic could not be convicted and sentenced for public drunkenness. Driver v. Hinnant, 356 F.2d 761, 763 (4th Cir. 1966). In so holding, the court found that alcoholism is a chronic disease and that alcohol can be addictive. *Id.* at 763-764. Easter v. District of Columbia, 361 F.2d 50 (D.C. Cir. 1966). *See* Whitlock v. Donovan, —— F. Supp. —— (D.D.C. 1984, No. 83-3388), Gesell, J. ("An alcoholic has a disease. He is the victim of a handicap which becomes progressively worse unless successfully treated."); *cf.* Robinson v. California, 370 U.S. 660 (1962), *reh. denied*, 371 U.S. 905 (1962) (drug addiction cannot be punished as a crime). Alcoholism also has been held to be a handicapping condition for purposes of the prohibitions of discrimination of handicapped individuals contained in the Rehabilitation Act of 1973, 29 U.S.C. § 791 *et seq.*, *Whitlock* v. *Donovan, supra.*

quate Alcoholism Programs, *Conference Proceedings, Alcoholism Insurance Coverage*, Washington, D.C. (January 9, 1980), at ii. As a result of this unenlightened attitude by insurance companies, thirty-seven State legislatures enacted legislation mandating insurance coverage for alcoholism treatment or mandating optional coverage.[10] These statutes merely mandate *minimum* require-

[10] Alabama, Code of Alabama, §§ 27-20A-1 to 27-20A-4 [1979]; California, West's Annotated California Code, Insurance Code: §§ 11512.14 and 10123.6, Health and Safety Code: § 1367.2 [1978]; Colorado, Colorado Revised Statutes, §§ 10-8-301 [1975] and 10-16-136 [1976]; Connecticut, Connecticut General Statutes, §§ 38-262b (1974), 38-373(a)(18) [1976], and 38-262f [1979]; Florida, Florida Statutes Annotated, § 627.669 [1982]; Hawaii, Hawaii Revised Statutes, § 393-7(c)(6) [1976]; Illinois, Illinois Annotated Statutes, Ch. 73, Para. 979(8) [1978]; Kansas, Kansas Statutes Annotated, Ch. 40-2, 105 [1977]; Kentucky, Kentucky Revised Statutes, § 304.18-130 to 304.18-180 [1980]; Louisiana, Louisiana Statutes Annotated, Revised Statutes, Title 22, § 215.5 (1982); Maine, Maine Revised Statutes Annotated, Title 24, § 2329; Title 24-A, § 2482; Title 28, § 475, sub-§ 2-A [1983]; Maryland, Annotated Code of Maryland, Art. 48A, § 490F [1981]; Massachusetts, Massachusetts General Law Annotated, Ch. 175, § 110; Ch. 176A, § 10; Ch. 176B, § 4A ½ [1982] and Ch. 176G, § 4 [1976]; Michigan, Michigan Compiled Laws Annotated, §§ 500.3425 and 500.3609a [1980]; Minnesota, Minnesota Statutes Annotated, § 62A.149 [1980]; Mississippi, Mississippi Code 1972 Annotated, §§ 83-9-27, 83-9-29, 83-9-31 and 83-9-35 [1974]; Missouri, Vernon's Annotated Missouri Statutes, § 376.779 [1980]; Montana, Montana Code Annotated, §§ 33-22-701 to 33-22-704 [1983]; Nebraska, Revised Statutes of Nebraska, 1980 Cumulative Supplement, §§ 44-769 to 44-781 [1980]; Nevada, Nevada Revised Statutes, Ch. 689A.030, Ch. 689A.046, Ch. 689B.030, Ch. 689B.036, Ch. 695B.180, Ch. 695B.194, Ch. 695C.170, Ch. 695C.174, and Ch. 608 [1983]; New Jersey, New Jersey Statutes Annotated, §§ 17B:26-2.1, 17B:27-46.1, 17:48-6a, 17:48A-7a [1977]; New Mexico, New Mexico Statutes Annotated, Ch. 64, Laws 1983 [1983]; New York, Consolidated Laws of New York, Annotated, Insurance Law, § 162(17) [1981]; North Carolina, General Statutes of North Carolina, § 58-251.6 [1984]; North Dakota, North Dakota Century Code Annotated, §§ 26-39-01 to 26-39-05 [1975]; Ohio, Ohio Revised Code Annotated, §§ 1739.01, 1737.20, 1737.29, 1738.24, 1738.25, 1739.19, 1739.20, 3923.28, 3923.29, and 3923.30 [1982]; Oregon, Oregon Revised Statutes, §§ 430.010, 430.315 and 743.557 [1983]; Rhode Island, General Laws of Rhode Island, Ch. 27-38-1 to 27-38-8 [1980]; South Dakota, South Dakota Codified Laws, §§ 58-18-7.1 and 58-18-7.2 [1978]; 58-41-35.1 [1979]; Tennessee, Tennessee Code Annotated, § 56-7-1003 [1982]; Texas, Vernon's Annotated Texas Statutes, Insurance Code, Art. 3.51-9 [1981]; Utah, Utah Code Annotated, § 31-20-2(6) [1981]; Vermont, Vermont Statutes Annotated, Title 8, §§ 4097 to 4100 [1981]; Virginia, Code of Virginia, §§ 38.1-348.7 [1979] and 38.1-348.8 [1978]; Washington, Revised Code of Washington, §§ 48.21.160, 48.21.190, 48.21.180 [1974], and 48.44.240 [1975]; West Virginia, West Virginia Code § 33-16-3c [1981]; Wisconsin, Wisconsin Statutes Annotated, § 632.89 [1977].

ments for alcoholism coverage. Thus, even where mandatory legislation is in effect "[r]estrictive statutes, regulations and policies continue to limit reimbursement . . . . For example, many States reduce public grant and contract funding if third-party reimbursement is received by a program. Other States place dollar limitations on benefits." National Institute for Alcohol Abuse and Alcoholism, "State Legislation on Health Insurance Coverage for Alcoholism Services: An Assessment," *Alcohol World* (Summer 1982), at 49.

To the extent that such mandatory laws exist, they generally accept the medical definition of alcoholism as a treatable disease which health insurance contracts often do not cover adequately. Such legislatures after careful deliberation have determined that the interests of their States' citizens "require that health insurance coverage be provided for the treatment of alcoholism." *Id.* The mandatory coverage statutes, thus, are "intended to facilitate early intervention into the illness and to result in cost and human savings for the individual citizen, the insurer and the State." *Id.*, at 49-50.

These laws generally fall into two categories: (1) legislation requiring certain health insurance policies to cover treatment of alcoholism; or (2) requiring the insurance carrier to make such coverage available to employers, organizations and other groups at their option.

All of the laws cover group insurance contracts, while some also govern individual insurance policies. Whatever form these State laws take, a number of compelling reasons justify such reasonable measures which are aimed at facilitating the treatment of a devastating and major disease in the United States.

III. ALCOHOLISM IS A TREATABLE DISEASE

The most persuasive medical argument in favor of mandatory coverage is that alcoholism can be, is, and indeed, should be treated. Such treatment falls into two categories, namely the setting of the treatment and the services provided during treatment.

A. Setting of Treatment

There are three general settings for alcoholism treatment: inpatient hospital care; outpatient care; and intermediate or residential care.

(1) *Inpatient Hospital Care Settings*

Inpatient hospital care settings generally accommodate patients with alcoholism who also suffer from the medical or psychiatric complications of alcoholism. These complications may include, but are not limited to, liver disease or psychotic diseases. These patients are under the care of a physician in an acute care bed located in a hospital or other similar medical facility. The immediate goal of this setting is to arrest the life-threatening complications of alcoholism. (This is the detoxification phase of a comprehensive treatment plan.) The second goal is to reach a psychological and social evaluation of the patient so that the physician and alcoholism counselors can establish a plan of treatment and rehabilitation for that particular patient, including after his or her discharge from the hospital. *Interim Report* at 1:36-37. *See also* Chafetz, Morris, "Alcoholism and Alcoholic Psychosis," *Comprehensive Textbook of Psychiatry-II* (1976), at 1,341.

The inpatient hospital care settings often play a critical role in alcoholism treatment by using the immediate medical crisis of the patient to motivate him or her towards long term sobriety. Indeed, studies demonstrate that the initial contacts with hospitalized alcoholics often make the critical difference in the patients' motivation to continue with alcoholism treatment. *Interim Report, supra*, at 1:37. *See also* Chafetz, Morris, "Motivation for Recovery in Alcoholism," *Alcoholism Behavioral Research* (1976); and Chafetz, Blane, Abram, Golner, Lacy, McCourt, Clark, and Meyers, "Establishing Treatment Relations with Alcoholics," *Journal of Mental and Nervous Diseases*, Volume 138 (1962), at 395-409.

(2) Outpatient Care Settings

Patients who are able to function in their usual environment but whose drinking habits have caused problems may be treated successfully in outpatient settings. These settings thus can either provide a follow-up therapy to patients leaving the hospital or intermediate settings or may serve as an alternative for more intensive care. Generally physicians, psychologists, social workers and alcoholism counselors are responsible for assisting the patient in these settings. Therapy in the outpatient settings is intended to help the patient solve current problems and to draw upon the support of those who have contact with the patient outside the treatment settings, such as family or employer, to help the patient remain sober. *Interim Report, supra*, at 1:40-41. *See also* Armor, Polich, and Stambul, *Alcoholism and Treatment* (1976), at 75. These settings often are found in general and specialty hospitals, alcoholism hospitals and other clinical settings.

(3) Intermediate or Residential Care Settings

The intermediate or residential care settings have been established for patients who are not suffering from acute physical or mental complications resulting from alcohol-

ism, but whose lack of adequate control necessitates treatment for their drinking problem in a drug-free setting. They provide structured settings intended to protect the patients from environmental stress and access to alcohol. By using a variety of optional modalities, such as psychotherapy, counseling, referral to Alcoholics Anonymous, and other patient and family education techniques, these settings are intended to alter the drinking behavior of the patients by changing the way he or she thinks or feels. These programs assess the patient's physical, psychological and social needs and develop a follow-up or alternative plan to supplement the therapeutic gains made during the residential stay. These programs are less intensive in their medical services, although they may exist in affiliation with general and specialty hospitals to treat the acute care patient, or with alcoholism treatment centers, community mental health centers and rehabilitation centers. *Interim Report, supra*, at I:38-39.

B. Alcoholism Treatment Services

There are three general alcoholism treatment services available to alcoholics. Acute phase services address medical emergencies and medical complications of alcoholism such as alcohol poisoning, which is acute alcohol intoxication when life threatening, and withdrawal syndrome. *Interim Report*, 1:45. Chronic phase services seek to modify the alcoholic's chronic drinking problem. These services usually include psychotherapy, counseling, family therapy, drug therapy, behavior therapy and referral to Alcoholics Anonymous. *Interim Report* at 1:47. Auxiliary services often found in inpatient and residential settings include board, occupational and recreational therapy. They may also provide outreach programs, follow-up and aftercare, consultation, and education. *Interim Report* at 1:53.

In summary, some patients respond to inpatient hospital care settings; some respond to outpatient care set-

tings and some to intermediate care settings. Whatever the setting or service, however, alcoholics can be successfully treated. *See* Office of Technology Assessment, "The Effectiveness and Costs of Alcoholism Treatment" (March 1983) ("OTA"). Early treatment of alcoholics results in lower medical costs and benefits not only the individual alcoholic and his immediate family, but also society as a whole. In order to facilitate treatment, however, insurance coverage is necessary.

IV. THE DISEASE OF ALCOHOLISM SHOULD BE COVERED BY INSURANCE POLICIES

There can be little doubt that alcoholism is a serious disease with severe consequences for the individual alcoholic and his or her family as well as for society as a whole. The disease of alcoholism, however, is treatable. In order to promote treatment, insurance coverage for such treatment should be made available to the disease's victims and States should be permitted to exercise their traditional insurance regulatory authority to mandate coverage. Most insurance companies, however, fail to provide adequate coverage. They historically have asserted that comprehensive benefits would increase premium costs, result in higher utilization of medical services by patients and that mandated insurance coverage law results in higher administrative costs to employers. The opposite is in fact the case.

Analyzing an NIAAA study which examined the cost implications of six model insurance benefit packages for alcoholism treatment, one commentator notes that when offset savings and other costs are considered insurance premium costs actually decrease. Fein, *supra*, at 55-56. He concludes that the "study makes it clear that the treatment of alcoholism, given its secondary effects, is a good buy: total health insurance premiums can decrease if alcoholism benefits are added to the insurance package." *Id.* at 56.

Equally puzzling is the insurance industry's concern that adding insurance benefits will increase utilization of medical services. A review of a summary of twelve studies concluded that alcoholism treatment was found to be "followed by reductions ranging from 26 percent to 69 percent in medical care utilization." Jones, Kenneth and Thomas Vischi, "Summary of Impact of Alcoholism Treatment on Medical Care Utilization and Cost," National Institute on Alcohol Abuse and Alcoholism (1979), at 1. Moreover, a "57% reduction in family member utilization following the initiation of treatment of alcoholic family members" was found. *Id.*

Alcoholics and their families use medical services, both inpatient and outpatient, more frequently than nonalcoholics. *Fifth Report* at 106. Yet current literature consistently reports that placing alcoholics in specific alcoholism treatment programs decreases their use of general medical services. *See* Regier, Darrell, M.D., "Epidemiology and Health Service Resource Allocation Policy for Alcohol, Drug Abuse and Mental Disorders," *Medical Benefits*, November 15, 1984, at 8. The primary treatment of alcoholism ultimately reduces the cost of medical coverage by elimination of recurring alcohol-related symptoms which need medical treatment. In other words, encouraging treatment of alcoholism by comprehensive insurance coverage actually would lower costs for the insurance industry.

Finally, employers also greatly benefit fiscally from adequate treatment of alcoholism. A 1979 report determined that following alcoholism treatment, the number of sick days taken by alcoholics decreased 38 to 47 percent. Fein, *supra*, at 55. As noted above, the detrimental effect of alcoholism on productivity is stunning and is yet another compelling reason to provide treatment for alcoholism and to encourage alcoholics to take advantage of such treatment.

One of the primary motivations to convince alcoholics to receive treatment is the provision of insurance coverage. Indeed, the costs of inpatient, residential and outpatient care should not be a disincentive to seek such care. An employee who recognizes that he or she has an alcohol problem may be reluctant to seek treatment if he or she is required to pay 100% of the costs. (This is not to say, however, that deductibles and coinsurance are not useful in providing alcoholics with a stake in their recovery.) The costs of adequate treatment may be an excuse to avoid treatment and if this reason is removed, the person may take advantage of treatment services. Most alcoholics do not seek treatment at all.

Early treatment, moreover, reduces costs as complications and health problems arising from alcoholism are forestalled. Sixty-sixth American Assembly, "Public Policy on Alcohol Problems—Final Report," *Alcoholism and Related Problems, supra.* "Shortening the course of the disease for the average alcoholic by even a few years would save billions of dollars and avoid much human misery, tragedy, and despair."[11] In a 1979 study, data kept over a four year span on twenty-six alcoholism treatment programs was reviewed. The study found that for each dollar invested in alcoholism treatment, two dollars were saved. Other studies have shown that reduced absenteeism of an alcoholic following treatment can result in over $1,000 savings. Additionally, employed alcoholics respond well to treatment and this results in a long period of sobriety. Thus, the cost savings increase as time goes on.[12]

In summary, available data demonstrate that the costs of not treating alcoholism exceed the cost of providing such treatment, particularly considering the indirect

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[11] Former Secretary of Health, Education and Welfare, Joseph Califano, *The 1982 Report on Drug Abuse and Alcoholism*, at 180.

[12] *Id.* at 177.

costs which are associated with the disease. *OTA*, *supra*, at 69. Employers have found that the costs of absenteeism, loss of productivity and training new persons to take over, permanently or temporarily, for the absent alcoholic, are greater than the costs for treating alcoholism.

V. CONCLUSION

For all of the foregoing reasons, the judgment of the Supreme Judicial Court of Massachusetts should be affirmed.

Respectfully submitted,

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